1. A joint health partner mission visited Kiribati from 15 to 25 February to progress work under the agreed program of analytical and technical assistance for 2016. The mission included representatives from the Australian Department of Foreign Affairs and Trade (DFAT) and the World Bank (WB) [1]. Mission objectives included: (i) supporting the Ministry of Health and Medical Services (MHMS) to improve its monitoring of the performance of the health sector and the way resources are being allocated and used to achieve desired results under the Kiribati Health Strategic Plan 2016-2019 (KHSP); (ii) completing a rapid review of progress in DFAT-funded public health and workforce development programs; and (iii) following up on country actions under the Pacific Non-communicable Diseases (NCD) Roadmap. The mission team also participated in the first health sector coordination committee meeting for 2016. As part of efforts to improve collaboration in the health sector, other key partners in Kiribati - particularly the New Zealand Ministry of Foreign Affairs and Trade (MFAT) and the World Health Organization (WHO) - joined the mission for meetings with the Ministry of Finance and Economic Development (MFED) and with MHMS[2].

2. The mission was undertaken in the context of the recent national parliamentary elections (held in December 2015) and presidential election (completed 11 March 2016). Ministerial appointments, including the Minister of Health, will be made by the incoming President.

3. The joint team thanks the Government of Kiribati (GoK), particularly MHMS and MFED, for the meeting arrangements and very productive discussions. The team also thanks program managers, other department heads and clinical staff for generously providing the opportunity to discuss their respective programs and activities.

Key Issues and Actions

A. Monitoring sector performance against the Kiribati Health Strategic Plan

Health Sector Coordinating Committee and Core Indicator Set for MHMS

4. GoK is making good progress in establishing arrangements to monitor overall health sector performance more effectively. The first health sector coordinating committee (HSCC) meeting for 2016 was held on 17 February at the Parliament House Conference Room, co-chaired by the MHMS Secretary and Deputy Secretary. A broad range of development partners participated including the Global Fund Principal Recipient for the Pacific multi-country grants (UNDP), UNFPO, UNICEF, WHO, DFAT, MFAT, Japan, and Fiji National University (FNU). The meeting considered a range of health system issues, including health and finance information needs, planning for health workforce and broader infrastructure requirements, as well as how to monitor impact and manage sustainable programs that are currently heavily reliant on external funding resources.

5. Driven by the MHMS management team, the HSCC is moving from a predominantly information sharing forum to one that has a more strategic focus on overall sector performance and policy dialogue; this is contributing to a stronger sense of partnership and

[1] External joint mission participants included: Rebecca Dodd (Director Pacific Health, DFAT), Rob Condon (Consultant Public Health Physician, DFAT), Peter Wallace (Economist and PFM Specialist, WB), Bob Flanagan (Senior PFM Consultant, WB) and Susan Ivatts (Senior Health Specialist, WB). Kiribati-based mission participants included: Kakiateiti Erikate (Program Manager, DFAT), Michael Hunt (Deputy Australian High Commissioner, DFAT).

[2] Other health partner participants in key meetings were Bereti Bureimoa (Development Program Coordinator, MFAT), Semilota Finauga (Senior Development Program Coordinator, MFAT), Ezekiel Nukuro (Country Liaison Officer, WHO) and Nandalal Wijesekera (WHO Consultant).

improved oversight and governance arrangements, as recommended in the *Health Financing Note* of July 2015[3].

6. MHMS is developing a draft Core Indicator Set for monitoring of the health sector at least annually**.** During the HSCC, MFED outlined an initial draft list of 15 indicators that it was proposing for monitoring health sector performance at least annually under the new Kiribati Development Plan (KDP), which will be finalised once the incoming Government is in place. The mission team and WHO assisted MHMS following the HSCC to review the draft indicators suggested by MFED, including their alignment with the proposed indicators for the KHSP, along with the draft Pacific Healthy Islands Core Indicators (which are being established at the request of the Pacific Health Ministers' Meeting in 2015), and the proposed indicators for the health specific Sustainable Development Goals. It was recognised that the selected indicators would ideally be drawn from existing routine data sources wherever possible, or have modest additional work involved, if they are to be reported on at least annually. Once finalised, it is anticipated that the KDP sector indicators will be used as a subset of the MHMS Core Indicator Set that will be reported on at least annually as part of routine monitoring of health sector performance against the KHSP. This annual routine reporting would be supplemented with data from less frequent population based surveys that are usually conducted every 5-10 years, e.g. the STEPwise survey for NCD risk factors, the Demographic and Health Survey, the Household Income and Expenditure Survey etc. (noting that such surveys are logistically complex and too expensive to be relied on for annual data capture). During the mission, the MHMS Secretary requested further consideration be given to the possible use of the District Health Information System (known as DHIS2) that is currently being used by a number of other Pacific countries.

Improving financial reporting

7. Good progress is being made by the MHMS Accounts Unit with transaction processing and completing reconciliations between the Attaché and Microsoft Access databases[4], but more needs to be done to complete accurate financial reports for GoK management. This includes reporting on both recurrent and development funds to give a more complete understanding of available resources and how they are being allocated and spent to achieve the KHSP strategic objectives; external funding is significant, accounting for around 30% of total health expenditure. Routine reporting also needs to reflect the level of arrears, which are currently substantial. In particular, slow payment of outstanding debts to international pharmaceutical suppliers contributes to stock-outs of essential medicines and is impacting negatively on aspects of disease control and service delivery. Resorting to emergency procurements usually adds substantially to the costs of supplies which further reduces the quality and efficiency of expenditure. More analysis of supply chain management and pharmaceutical expenditure is needed to help ensure these concerns are addressed.

8. The World Bank team will continue working with MHMS Accounts Unit and MFED to generate regular monthly finance reports that capture both recurrent and development expenditure, as well as to complete a full 2015 financial report for the health sector. MHMS management has indicated that they would find such regular finance reports extremely useful to help make more timely, evidence-informed modifications to financing and implementation arrangements where needed. The 2015 report will be used to inform the Joint Annual Performance

[3] World Bank (2015) *Kiribati Health Financing Note*

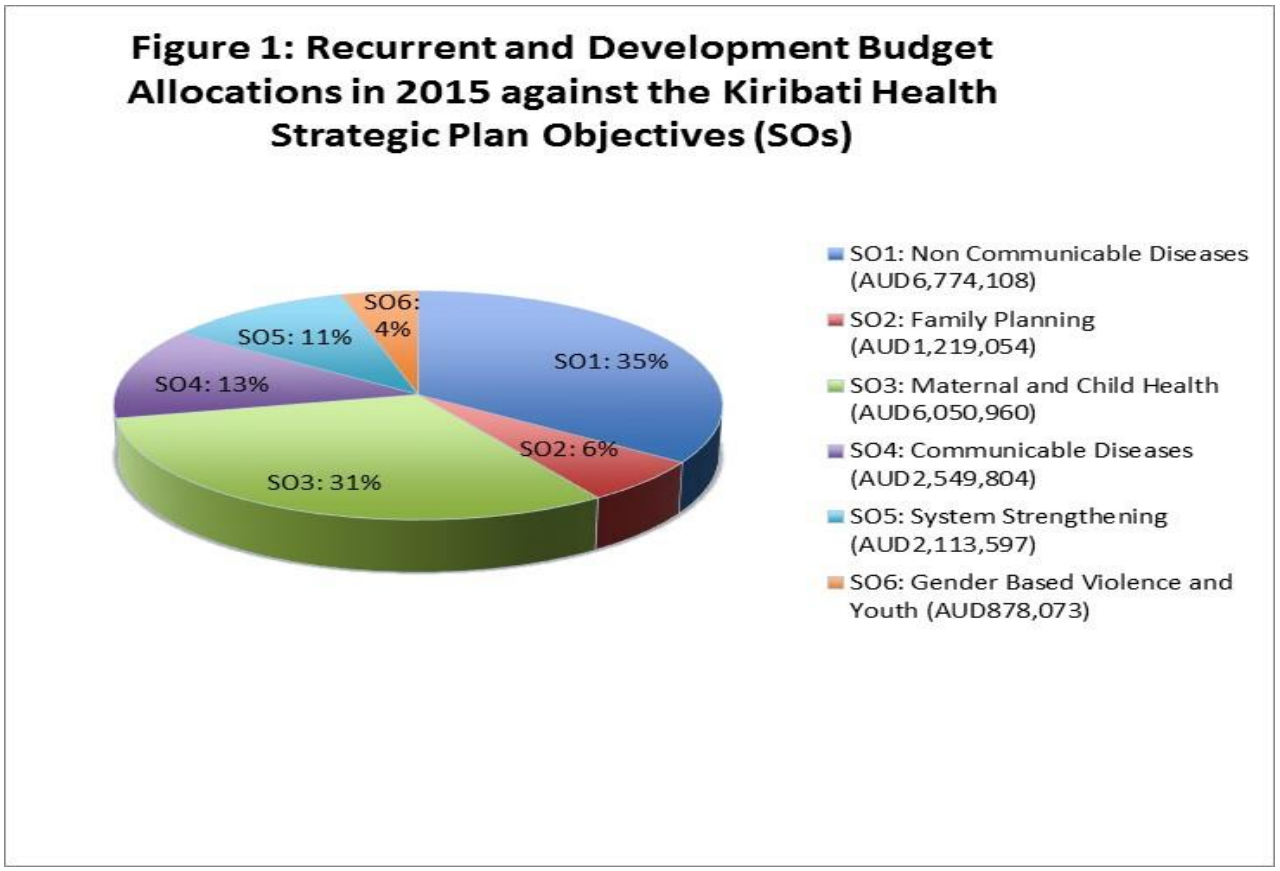
[4] As noted in the December Aide-Memoire, Attaché does not allow for tracking of commitments so having an accurate Microsoft Access database is important for providing a complete picture of the financial situation for MHMS.

Review (JAPR) of the Health Sector for 2015 (see paragraph 11). The team will also work with MHMS using the Trial Balance for 2015 when available to update the trend data in the *Health Financing Note* to inform JAPR discussions.

9. MFED noted that it will be completing a review of the Attaché financial database with support from the Asian Development Bank this year, and considering an alternative financial management information systems (FMIS). This review will provide a good opportunity to reflect on how the GoK finance system might align more effectively with key sector strategies, annual plans and program reporting so that GoK can track allocations and expenditure against the stated priorities in the KDP and sectoral strategic plans. From a health sector perspective the current limited FMIS only allows analysis according to the categories of ministry, division, and economic item, account code, budget allocation and actual expenditure. These filters do not allow any direct assessment of spending against the priorities or outcomes of the KHSP, or against detailed service levels. The FMIS also does not allow for any thorough sub-national or outer island classification of budgets or expenditures. MFED noted that there is capacity to record additional classifications of recurrent budgets and expenditure but this is not currently used. A modified or new FMIS would provide an opportunity to reflect this kind of detail to help assess distribution of funds, and the equity and results of health spending. The MFED strategic plan also notes the intention to introduce program budgeting by 2019. This would provide a standard, Government-wide framework for determining objectives and priorities, coordinating sources of funds and tracking outlays according to sectoral objectives and priorities. Any new or revised FMIS will need to incorporate sufficient functionality to support this program budgeting initiative.

10. The interim efforts of MFED to improve the FMIS through addition of a Microsoft Access database at ministry level are welcome. This database allows for the recording of expenditure commitments and for reporting against GoK and development partner funds.

11. As a first step in bringing together health and finance information more effectively, the team facilitated a workshop with MHMS to develop a methodology for allocating the budget of MHMS' divisions to the six strategic objectives of the KHSP; preliminary results are shown in Figure 1. NCDs and RMNCH (including childhood and maternal vaccination) receive the largest proportion of funding, which is considered appropriate given the relative burden of disease. This analysis will assist MHMS to: (a) increasingly link the annual budget process to strategic priorities and annual operating plans for the sector; (b) monitor and report on expenditure against priorities; and (c) take a progressively more whole-of-sector approach to the allocation, use and monitoring of resources – including external funding. More work is needed to refine this methodology and the underlying assumptions about work load at the primary care level (including differentiation of preventive and curative interventions); however, initial feedback from MFED and MHMS is that it helps to inform the understanding and discussion on how resources are being allocated and used to achieve the desired results in the health sector. Using this methodology alongside the core indicator set and financial reports will strengthen the understanding on how resources are being allocated and used against the stated priorities in the KHSP and KDP.



Joint Annual Performance Review of the Health Sector

12. MHMS will host its first Joint Annual Performance Review of the Health Sector on 12-13 May 2016, combined with the annual Health Forum. WHO is assisting MHMS to complete a report for 2015 against the initial core indicator set (paragraph 6). Bringing together analysis on the health and finance data for 2015 will be an impressive step forward for GoK in monitoring the performance of the health sector to inform ongoing planning and budget management decisions.

Health Services Master Plan

13. MHMS has developed a draft Health Services Master Plan that addresses 7 health sector 'domains': health workforce; pharmaceutical procurement and supply chain management; diagnostic and treatment equipment; service delivery and accessibility; health facilities and buildings; HIS, and information and communications technology; and utilities (e.g. water and electricity). The draft Plan was developed with technical assistance from WHO. The draft Plan also starts to explore key themes around models of service delivery for hospitals, public health and nursing. This sort of role delineation process will provide important guidance for future infrastructure development and human resources for health (HRH) planning.

14. WHO and the MHMS are awaiting comment and feedback from internal stakeholders and development partners in order to refine the draft Health Services Master Plan. There will be an opportunity to review this feedback and to further develop infrastructure and HRH planning when the WHO consultant returns to Kiribati to facilitate a hospital quality assurance workshop on

10-11 May 2016. In the meantime, WHO will support MHMS to collate feedback and identify key next steps in advance of the anticipated follow-up discussions after the May workshop.

B. Specific program/project issues

Non-Communicable Diseases

15. The mission team followed up with MFED and MHMS on progress against the Pacific NCD Roadmap following the endorsement and commitment by the joint Economic and Health Ministers in 2014 to the following five key actions:

i. strengthening tobacco control by an incremental increase in excise duties to 70% of the retail price of cigarettes over the medium term;
ii. considering an increase in taxation of alcohol products as a way of reducing harmful alcohol consumption;
iii. considering policies that reduce consumption of local and imported food and drink products that are high in sugar, salt and fat content and directly linked to obesity, diabetes, heart disease and other NCDs in the Pacific through targeted preventative measures, taxes and better regulation;
iv. improving the efficiency and impact of the existing health budget by reallocating scarce health resources to targeted primary and secondary prevention of cardiovascular disease and diabetes, including through the Package of Essential NCD (PEN) Interventions of 'best buys'; and
v. strengthening the evidence base for better investment planning and programme effectiveness to ensure interventions work as intended and provide value for money.

16. MFED advised that its paper on tobacco and alcohol taxation remains ready to go to Cabinet in coming months, once the in-coming government is in place; the paper was prepared last year with assistance from WHO. MHMS noted that there is some evidence that tobacco related behaviours are changing, giving the example of increasing numbers of maneabas being designated as smoke-free. WHO noted that completion and analysis of the latest STEPwise approach to Surveillance for NCD risk factors (STEPS survey) in Kiribati has been delayed and a final report will not be available until later in 2016. This is a setback given the valuable trend data that the STEPS survey is expected to provide to inform ongoing NCD related programs of work, including efforts to tailor the PEN to the available resources, operating context, and epidemiological risk profile for Kiribati. The MHMS Secretary stated that he would make available to partners the NCD costing study completed by WHO through Deakin University to help inform collective efforts to maximise resources available for NCDs.

17. While it is acknowledged that emphasis needs to be placed on well targeted and effective health promotion and early prevention and treatment options, the reality is that rehabilitation services for people with amputations will represent a significant part of the response to the NCD epidemic for the coming generation. Construction of the new Rehabilitation Centre at Tungaru Central Hospital (TCH) is complete, and the rehabilitation workforce will be boosted over the next three years by three prosthetists returning from training in Cambodia and up to seven physiotherapy graduates returning from FNU. DFAT is currently in discussion with the TCH Rehabilitation Centre, Motivation Australia and a local faith-based organisation (FBO) about implementing a collaborative program to reduce amputation rates among patients with diabetic peripheral vascular disease and foot ulcers through a low-cost, non-operative intervention known as 'off-loading'. The technique aids wound healing by reducing direct pressure through diabetic foot ulcers while keeping the patient ambulant. It has been piloted in TCH

outpatients since 2015, and early results are promising. The expanded program will include a data management module that will link with the proposed core indicator set (paragraph 6) through the lower limb amputation rate in patients with known diabetes.

Reproductive, maternal, neonatal, child and adolescent health (RMNCAH)

18. The joint UN agencies RMNCAH Program has little to report in Kiribati, where activities have been much slower to commence than in the Solomon Islands and Vanuatu. The Program is funded by the DFAT Pacific Regional aid program and implemented by three UN agencies in three Pacific countries: UNFPA is the lead agency in Kiribati, WHO in Solomon Islands and UNICEF in Vanuatu. The Program has a dual strategic focus: a) Joint UN programming, and b) support for improved RMNCAH services and outcomes in the three countries.

19. The Program planning activities to date have included: recruitment of a UN level P4 Program Coordinator to be based in Tarawa; plans to place a locally engaged Finance Officer in the MHMS Accounts Unit (to assist the MHMS to access Australian funding via UN financial systems); and plans to renovate some office space for the team in the MHMS. A UNFPA consultant was in Kiribati during the joint donor mission, undertaking a gap analysis and initiating planning activities for RMNCAH program-strengthening activities and interventions. Her draft report was due on 29 February 2016.

20. Government and partners encouraged UNFPA to share implementation plans and, subject to MHMS endorsement, to commence activities at the earliest opportunity. Government and partners were of the opinion that it would be inappropriate to engage a UNFPA Finance Officer for the full duration of the Program. The MHMS Accounts Unit is relatively well staffed with a low per capita work load (see paragraph 31), and the UN agencies should be making use of Government systems to mobilise Australian RMNCAH resources. The mission did note some shortcomings in pharmaceutical procurement and supply management (PSM) processes, suggesting that additional UN technical assistance would potentially be better utilised in strengthening commodities procurement (this links in to the Health Services Masterplan noted above).

Tuberculosis

21. The current National Tuberculosis Strategic Plan (NTBSP) concluded in 2015. With the highest TB rates in the Pacific (excluding PNG), TB remains a very high public health priority in the KHSP and KDP. The Australian-funded Towards Tuberculosis Elimination in Kiribati (TTBEK) Project has been implemented by the Secretariat of the Pacific Community (SPC) in collaboration with the National TB Program (NTP) since late 2012. A mid-term evaluation (MTE) was undertaken in December 2015 with the aim of guiding transition to the final phase of Australian funding for the Project, during which all externally managed functions would be progressively absorbed into the NTP and MHMS systems. The final MTE report is still pending.

22. An increase in the number of TB cases diagnosed in 2015 has revealed current and potential further short-falls in TB drug supply during 2016. WHO has assisted in emergency relocation of some surplus from Papua New Guinea's first-line drug stockpile, and a second relocation is likely to be necessary before the revised Kiribati order is received. The national Pharmacy is completely isolated from TB PSM processes.

23. MHMS Secretary noted the urgent need for an updated five-year NTBSP. The NTP will take a lead role in developing the updated NTBSP, which should attempt to address social determinants of health in relation to the TB epidemic in Kiribati as well as focusing on TB technical

and management issues (including TB-diabetes co-morbidity). Collaborative funding opportunities aligned with climate change and/or innovation agendas should be explored; this may include interventions like: pilot housing strategies in identified TB hot spots, and innovative advocacy, communication and social mobilization strategies to promote stronger community and multi-sectoral engagement and political leadership.

24. SPC's reported under-expenditure of AUD 610,221 against the TTBEK Phase 1 budget will likely be used to maintain continuity of key NTP services and development of the revised and updated NTBSP. Subject to the findings and final recommendations of the MTE, a no-cost extension to mid-2016 to cover these activities is currently under negotiation between DFAT, SPC and MHMS.

25. MHMS has also requested partner support to develop the costed Transition Plan over the period of the new NTBSP. The Transition Plan would map all TB resources, including Australian funding previously reserved for TTBEK Phase 2, against a single work plan and budget and progressively ensure Government assumes full managerial and financial responsibility for the NTP (including HR, PSM and information management functions). Australia has offered to provide technical assistance; additional technical support is available through the multi-donor trust fund with the World Bank which was recently established to support countries to integrate donor financed, disease specific health programs into mainstream government functions.

Kiribati Internship Training Program

26. The Kiribati Internship Training Program (KITP) is progressing well. The KITP is a competency-based program designed to ensure that foreign-trained medical graduates (FTMG) are well supported to enter the Kiribati health system and to practise safely. It is implemented in close collaboration with the FNU College of Medicine, Nursing and Health Sciences (CMNHS), which has directly managed the first two years of the Program. A Governance and Coordination Committee (GCC) is in place, and management systems (including for financial management of donor funds from Australia and elsewhere) are relatively mature.

27. A Transition Plan, endorsed by GCC, is in place to guide the gradual integration of the program into full Government ownership and management by 2020-21. The Transition Plan maintains a prominent role for CMNHS in quality assurance and assessment, but under steadily increasing MHMS leadership, management and financial responsibility for the Program.

28. An external evaluation has been scheduled for when the majority of the first cohort has completed its program – most likely in May 2016. Among the 21 FTMGs in the first cohort, seven are currently completing their internship program, seven are on track to finish soon, and seven have experienced delays (for a variety or personal or academic reasons) but are expected to complete the Program during 2016 with some extra time and support.

29. The KITP is evolving into a sub-regional program, having just taken on a second cohort of 8 Cuban-trained medical graduates from Tuvalu. They will be joined later in 2016 by a small number of Cuban-trained graduates from Kiribati and Tuvalu and possibly two Tuvaluan graduates trained in another regional institution.

30. Australian funding of salaries for three international KITP supervisors is about to conclude, while funding for FNU operational support and quality assurance will conclude in

mid-2016; Funding from alternative donor sources remains available for one supervisor. The Australian bilateral program has been able to mobilise sufficient funds to cover supervisor salaries to the end of June, and New Zealand has indicated that it is then willing to cover the funding shortfall in the Transition Plan for the next two years (i.e. from July 2016).

C. Other activities in the WB program of Technical and Analytical Assistance

Functional Analysis of the Accounts Unit in MHMS

31. In consultation with MFED, the WB team commenced work with MHMS on a functional analysis for the Accounts Unit, looking at key roles and responsibilities; it is expected this will be completed in May. Job Descriptions for the Accounts Unit staff were not accessible during the mission but MFED is following up on this. Initial assessment is that there is an over reliance on manual processes that could be rationalized considerably to improve productivity and efficiency. Given the current understanding of work processes and volume of transactions, the initial perception is that the Accounts Unit is well staffed. Until the functional analysis can be completed in May 2016, with greater clarity on Accounts Unit roles and responsibilities, the mission team recommended caution about additional finance positions being funded by development partners e.g. under the RMNCAH program through UNFPA (paragraph 20). For this same reason, WB will continue for now to provide technical assistance via current arrangements, with Peter Wallace spending approximately two weeks every two months in Kiribati, with regular inputs from Bob Flanagan and Susan Ivatts.

Capacity development targets for the Accounts Unit in MHMS

32. To ensure a strong focus on building the skills and capacity of GoK officials to support better management of available resources, two capacity development targets were agreed for 2016: (i) more timely **monthly reconciliations** between Attaché and Microsoft Access databases; and (ii) improved **financial reporting on a monthly basis** (picking up on the issues outlined in paragraphs 7). Without improved capacity in these areas, MHMS and MFED management are not able to monitor resource allocation and use the resulting information in a timely way. The current lack of accurate information on allocations and expenditure – for both recurrent and development funds - impacts on service delivery and ultimately health outcomes. This is demonstrated by the significant outstanding bills/arrears. These capacity development targets will help guide the WB's program of work over 2016.

Possible use of future International Development Association (IDA) funds for the health sector

33. The mission team raised with the new MFED Deputy Secretary the possibility of GoK using some IDA for continued health sector reform over coming years, focused on improving health service performance and outcomes. This followed up on discussions during the joint partner missions in 2015 on a possible results based financing operation in health. One new option raised was the potential to use IDA with possible cofunding from other partners for a health development policy operation (DPO)[5]. MFED indicated that the incoming Government would be looking at options for use of IDA funds in the context of the next KDP. These discussions and

[5] GoK is familiar with the DPO financing instrument through its Economic Reform Program (ERF). Under the ERF and DPO arrangements, a joint policy matrix is prepared, that sets out an agreed program of reform between GoK and all key funding partners— the DPO budget support is provided against those reforms. Current ERF DPO funders are WB, ADB, and New Zealand. Australia and the International Monetary Fund also provide input to the policy matrix.

options will be followed up during the May joint partner health mission, i.e. once the incoming Government is in place.

D. Next Steps

34. Agreed actions between GoK and partners from this joint health mission are:

a) MHMS will finalise and send its feedback to MFED on the draft KDP health indicators.

b) MHMS will finalise the core indicator set and use reporting on this to inform discussion on performance in 2015; WHO is assisting the MHMS HIS Unit to complete this work.

c) World Bank health team will continue its program of work assisting the Accounts Unit with the preparation of the 2015 Financial Report, and updating the financing trend data from the Health Financing Note to inform discussions at the JAPR in May.

d) World Bank will continue to work with MHMS to refine the methodology for allocation and expenditure analysis against the KHSP strategic objectives (building on work outlined in paragraph 11).

e) WHO and World Bank will assist MHMS with further consideration of its current HIS arrangements and explore whether DHIS2 is a suitable option for.

f) WHO will collate responses to the draft Health Services Master Plan and assist MHMS to map out the next steps in developing the health workforce and infrastructure plan.

g) FNU will engage a consultant to review the first KITP cohort, and will then share the results of the evaluation with GOK, the KITP GCC, New Zealand and other partners.

h) Subject to the findings and recommendations of the TTBEK MTE, the SPC project management team will assist MHMS to update the NTBSP in line with the KHSP; the revised NTBSP should reflect, wherever possible, genuine inter-sectoral collaboration and partnership to address the interface with diabetes and the social determinants of health (particularly housing) that contribute to the TB epidemic in Kiribati.

i) Once the updated NTBSP is in place, DFAT and WB will assist in the Transition Plan work, linking with Global Fund and other partners supporting TB activities.

j) DFAT will closely monitor the proposed RMNCAH investment plan as it becomes available, ensuring commencement of in-country activities as soon as possible (in close consultation with the joint UN agency Technical Working Group in Suva).

k) MHMS will share the WHO-funded NCD costing study with development partners involved in NCD implementation support work (copies have now been received by partners).

l) WB and WHO will assist MHMS to document progress on the key taxation and other actions agreed to by joint Health and Finance Ministers in the Pacific NCD Roadmap

m) DFAT, Motivation Australia and their FBO partner will liaise with MHMS through the TCH Rehabilitation Unit about expansion of the pilot 'off-loading' program for reducing lower limb amputation rates among patients with diabetic vascular disease and foot ulcers.

n) MHMS, with joint partners, will discuss with MFED the potential for future use of IDA allocations for the health sector.

35. It was agreed that the next joint partner mission would be in May and include support for preparations and participation in the JAPR.